be made public in its final form and, through some energetic public health action during the remainder of this decade, the rest of the Western Pacific region will implement comprehensive tobacco control strategies that will come to be just as successful as Singapore's. The future health of millions of Asian adolescents depends on it.

1 Taking stock. *Tobacco Reporter*. April 1994, p 30.
2 Emmanuel SC, Chan AS, Phe A. Cigarette smoking in Singapore. *Singapore Med J* 1988; **29**: 119–24.
3 National Health Survey, 1992. Ministry of Health, Singapore, 1993.

From the International Union Against Cancer

INTERNATIONAL UNION AGAINST CANCER
Tobacco and Cancer
Programme

Africa – a desperate need for data

Annie J Sasco

With such a title, in an article dealing with public health, the first topic which comes to mind is AIDS. But this is not the topic I would like to address in this column. Another huge threat to the health of Africans currently exists which could kill millions of the young people alive today and the dangers of which we know perfectly well: tobacco.

In order to implement adequate policies to prevent the further spread of the tobacco epidemic, it is crucial that simple studies be implemented rapidly so as to make a real evaluation (not based on assumptions) of the risks associated with tobacco use in the African setting. These data will not only be of scientific interest, but will also represent a real public health achievement.

Evaluation of tobacco-related mortality and morbidity in Africa

In order to evaluate this burden correctly, one needs to have precise statistics concerning three items:

1. Occurrence (mortality or preferably incidence) of cancers, cardiovascular diseases, and chronic obstructive pulmonary disease.
2. Prevalence of tobacco use in its various forms and not only manufactured cigarettes.
3. Last but not least, the precise relationship between tobacco use and disease for each specific country.

The availability of such data varies greatly from one country to another. Even data on mortality are extremely limited. It has been estimated that cancer mortality data only exist for about 9% of the African population and data for cancer incidence for 0.5%. The situation is even worse for diseases for which the diagnostic criteria are somewhat less clear than for cancer.

For cancer, some incidence data exist. In the most recently published edition of *Cancer incidence in five continents*, three African cancer registries were included. This clearly demonstrates the feasibility, in spite of many difficulties, of collecting high quality and reliable information on the occurrence of cancer in Africa. Overall cancer rates in men, after adjustment to the world population, are highest in Bamako (121.9 new cases per 100000 person-years), intermediate in Setif Wilaya (72.2), and lowest in The Gambia (59.1). The ranking is similar among women with figures of 102.9, 65.4, and 39.6, respectively. Women therefore experience lower overall cancer rates than men. A more than tenfold difference exists for the occurrence of lung cancer. The highest male incidence is found in Setif Wilaya at 11.7 per 100000 versus 2.6 in Bamako and 1.0 in The Gambia. Among women, lung cancer rates are still very low, from 0 in The Gambia to 2.6 in Bamako.

Pioneering work has started at the International Agency for Research on Cancer (IARC) to estimate the proportion of human cancer linked to tobacco use on a world scale. In eastern and western Africa and with the methodology being used, no attributable fraction due to tobacco is yet discernible. This probably reflects the low prevalence of these diseases in these populations, as well as all the uncertainties surrounding the data and the adequacy of methods for countries with low rates of the disease considered. In the rest of Africa, tobacco is already responsible for a noticeable part of these cancers, especially among men.

Preparing the ground for better data

The International Development Research Centre (Ottawa, Canada) and the International Union Against Cancer in collaboration with IARC and the World Health Organisation have recently started pilot studies in ten African countries (Egypt, Ghana, Kenya, Nigeria, Senegal, South Africa, Sudan, Tanzania, Uganda, and Zambia) in order to collect basic information on tobacco use (various forms) and possibly tobacco-related mortality and morbidity (lung cancer in particular). Finally, an economic study is also planned. These data will not only be of scientific interest, but will also provide us with the information tools we need to convince African leaders, as well as international public health experts, of the importance of promoting an active anti-tobacco policy in Africa.

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